Aswad Surgical Group
Health History Questionnaire

Name: _____ Date of Birth: _____ Age: _____
Pharmacy: _____ Primary Care Provider: _____
Best contact number: _____ Email:_____

Things I would like to discuss with the provider today:

1. _____ 2. _____

PERSONAL MEDICAL HISTORY

Chronic Medical Conditions (please check all that apply):

- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ High cholesterol
- ☐ Diabetes
- ☐ Stroke
- ☐ Cancer _____
- ☐ Chronic pain for which I see a pain clinic
- ☐ Thyroid
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Kidney Problems
- ☐ Anemia
- ☐ HIV
- ☐ Arthritis
- ☐ Back pain
- ☐ Irritable bowel
- ☐ Crohn's
- ☐ Ulcerative Colitis
- ☐ Liver disease
- ☐ Hepatitis
- ☐ Diverticulosis
- ☐ Colon Polyps
- ☐ Acid Reflux (GERD)
- ☐ DVT
- ☐ PE
- ☐ Depression/Anxiety
- ☐ Other_____

Previous Surgeries/Procedures (please check all that apply):

- ☐ Gallbladder
- ☐ Appendix
- ☐ Total Hysterectomy
- ☐ Partial Hysterectomy
- ☐ C-section
- ☐ CABG
- ☐ Heart stent(s)
- ☐ Colon Resection
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Lumpectomy
- ☐ Mastectomy
- ☐ Colonoscopy
- ☐ EGD
- ☐ Orthopedic
- ☐ Other_____
- _____
- _____
- _____

Height: _____ **Weight:** _____

Allergic to Latex? ___Yes ___No

Sensitive to Latex? ___Yes ___No

Do you take Aspirin? ___Yes ___No
Do you take Plavix? ___Yes ___No
Do you take a blood thinner? ___Yes ___No
Problems with anesthesia? ___Yes ___No

Allergies and/or Intolerance to Medications:

_____ _____
_____ _____
_____ _____

Medications you are taking including over-the-counter meds/supplements (with dose & frequency)**:**

☐ Check here if you have a Medication List and we will make a copy.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

TURN OVER

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SOCIAL HISTORY

Marital Status ___Single ___Married ___Divorced ___Widowed Number of Children____

Do you use smoke now? ___Yes ___No

How much? _____ How long? _____

Do you use chew/snuff? ___Yes ___No

Have you used tobacco before? ___Yes ___No

Street drugs? _____

Occupation _____

Does your job entail heavy lifting? ___Yes ___No

Alcohol _____ drinks per week

Caffeine _____ cups per day (coffee, tea, soda)

Water_____ cups per day

FAMILY HISTORY

	Living (Yes/No)	List medical conditions (diabetes, cancer, heart disease, etc.)
Father	___Yes ___No	_____
Mother	___Yes ___No	_____
Brother(s)		_____
Sister(s)		_____
Children		_____

REVIEW OF SYSTEMS (please check all that apply)

Systemic symptoms
- ☐ Weight change
- ☐ Chills
- ☐ Fever
- ☐ Night sweats
- ☐ Feeling tired

Head symptoms
- ☐ Headache
- ☐ Facial pain
- ☐ Sinus pain

Eye symptoms
- ☐ Eyesight problems
- ☐ Eye pain

Ear/Nose/Throat Symptoms
- ☐ Ear pain
- ☐ Hearing loss
- ☐ Nasal discharge
- ☐ Hoarseness
- ☐ Throat pain

Neck symptoms
- ☐ Neck pain
- ☐ Neck stiffness
- ☐ Lump/swelling neck

Breast symptoms
- ☐ Breast pain
- ☐ Nipple discharge
- ☐ Breast Lump

Heart symptoms
- ☐ Chest pain
- ☐ Fast heart rate
- ☐ Palpitations

Pulmonary symptoms
- ☐ Shortness of breath
- ☐ Cough
- ☐ Wheezing

GI symptoms
- ☐ Change in appetite
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stool
- ☐ Bloody stool
- ☐ Rectal pain
- ☐ Hernia

Urinary symptoms
- ☐ Painful urination
- ☐ Blood in urine

Skin symptoms
- ☐ Abscess
- ☐ Cyst
- ☐ Rash
- ☐ Itching

Endocrine symptoms
- ☐ Excessive sweating
- ☐ Excessive thirst
- ☐ Excessive hunger

Musculoskeletal Symptoms
- ☐ Joint pain
- ☐ Muscle pain

Neurological symptoms
- ☐ Dizziness
- ☐ Vertigo
- ☐ Fainting
- ☐ Weakness
- ☐ Sensation changes

Psychological Symptoms
- ☐ Insomnia
- ☐ Anxiety
- ☐ Depression
- ☐ Stress

Other symptoms
- ☐ _____
- ☐ _____
- ☐ _____

Recent Radiology/Tests
- ☐ EGD Date_____
- ☐ Colonoscopy Date_____
- ☐ Mammogram
- ☐ Breast Ultrasound
- ☐ CT Scan Abdomen
- ☐ Barium swallow
- ☐ HIDA scan
- ☐ Gallbladder Ultrasound
- ☐ MRI _____
- ☐ Blood tests

TURN OVER